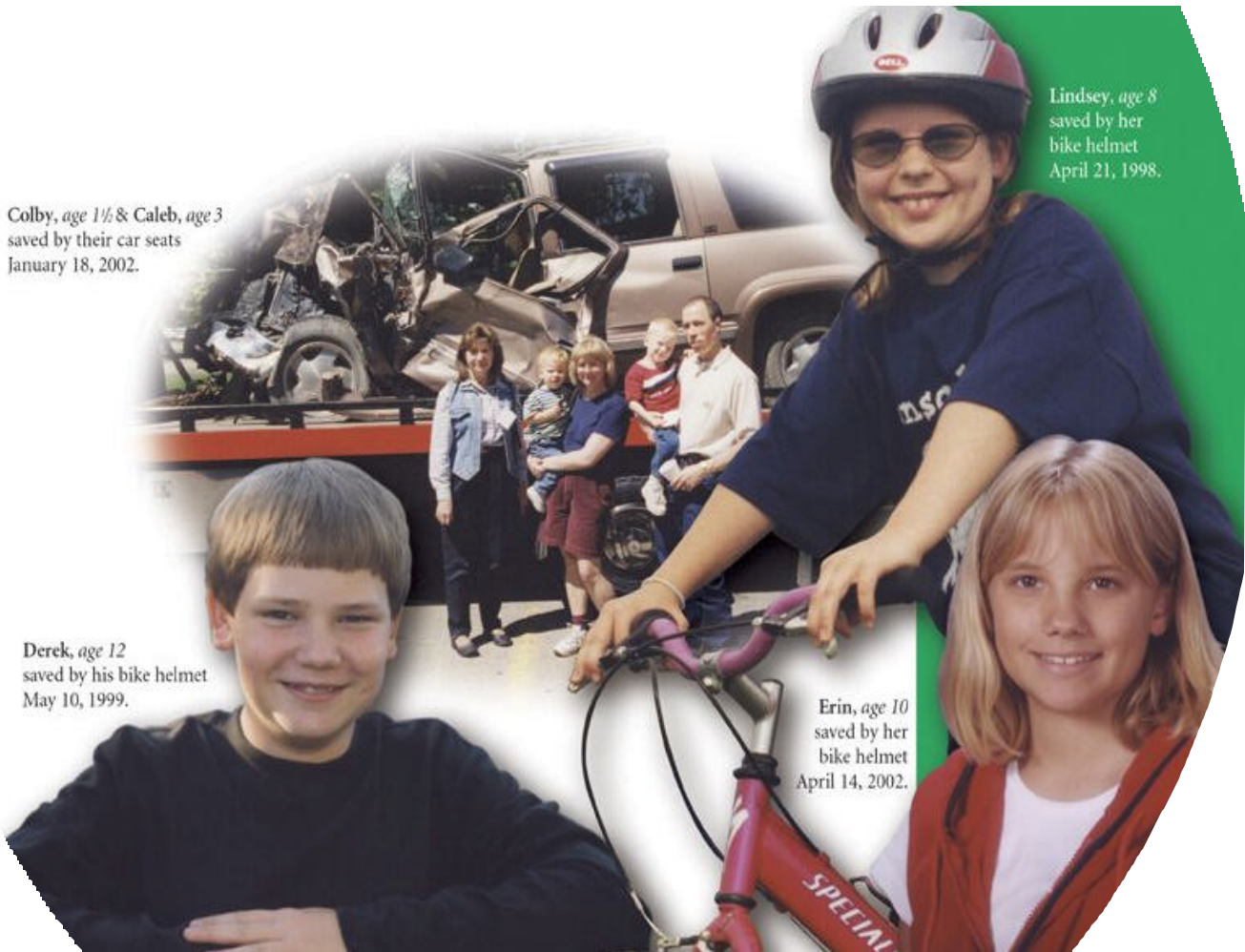


Kansas **SAFE KIDS**

A PROGRESS REPORT ON UNINTENTIONAL INJURY IN KANSAS CHILDREN

Colby, age 1½ & Caleb, age 3
saved by their car seats
January 18, 2002.



Lindsey, age 8
saved by her
bike helmet
April 21, 1998.

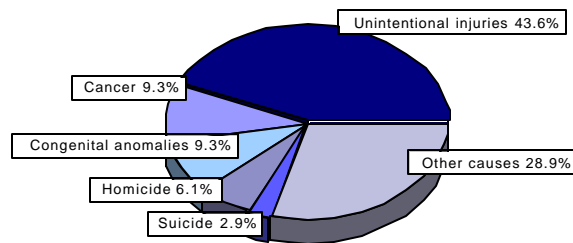
Derek, age 12
saved by his bike helmet
May 10, 1999.

Erin, age 10
saved by her
bike helmet
April 14, 2002.

SUMMARY

This progress report presents a detailed picture of many of the risks that kill Kansas children. Unintentional injury cause more deaths than disease, homicide or suicide in Kansas children ages 1-14.¹

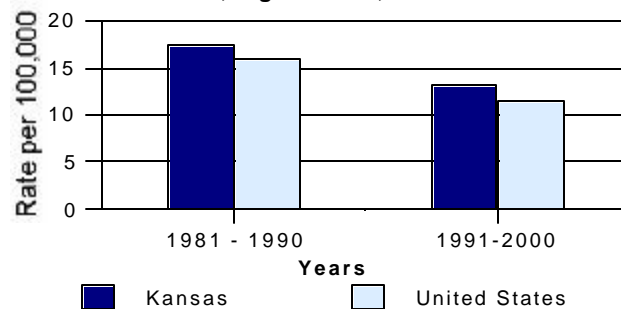
**Leading Causes of Death in Children
Ages 1-14, Kansas, 1999-2000 (n=280)**



Source: National Center for Health Statistics, CDC¹

When comparing the 1981-1990 and 1991-2000 time periods, there was a 24% decrease in death rates per 100,000 population caused by unintentional injuries in Kansas compared to a 28% decrease nationally.¹

**Mortality due to Unintentional Injury
Deaths, Ages 0-14, 1981-2000**

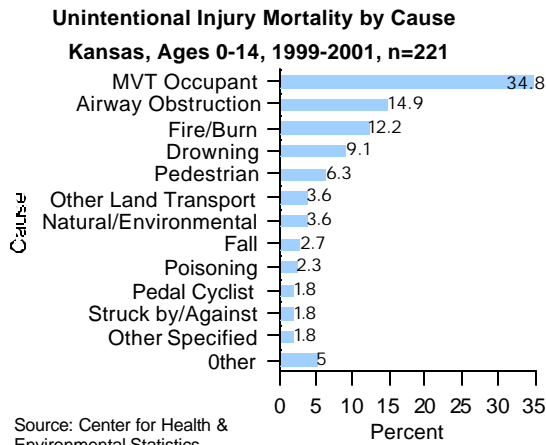


Source: National Center for Health Statistics, CDC¹

In fact, in Kansas, in the years ranging from 1991-2000, there was a decreasing trend in the unintentional injury death rate in the 14 and under population, while there was an increase in unintentional injury death rates in the general population.² Decreases in unintentional injury rates for occupants of motor vehicles, pedestrian, and airway obstruction exceeded decreases nationally when compared to the same time period (1981-1990 and 1991-2000). Other encouraging news is that in the same time period bicycle injury death rates have decreased 30%, fire/burn injury death rates have decreased 27%, and pedestrian injury death rates have decreased an astounding 50%.¹

Despite these encouraging decreases in injury death rates, too many children are still improperly restrained when riding in motor vehicles, or are unprotected by a bike helmet or working smoke detector. In Kansas, while no unintentional injury risk area saw an increase in injury death rates, decreases in unintentional poisoning, firearm, fire and burns, falls, drowning, and bicycle injury death rates lag behind decreases nationally.¹

Crashes involving occupants of motor vehicles in traffic remain the leading cause of unintentional injury-related death among children 14 and under, despite a primary child occupant protection law and multiple campaigns to promote safety belts and child safety seats.² In 2001, 85% of the Kansas children 0-14 killed in motor vehicle crashes were riding unrestrained.¹³

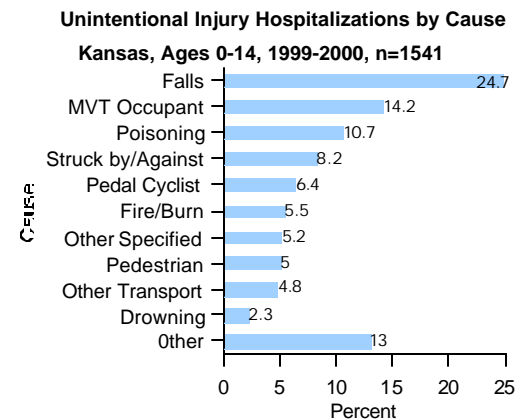


These factors help explain why, when comparing 1981-1985 and 1996-1998, that although much progress has been made in reducing death rates among occupants in motor vehicle crashes in the 0-4 age group (53%), much less progress is demonstrated in the 5-9 age group (3.7% reduction) and a disappointing increase is found in the 10-14 age group (14% increase).¹

The five leading causes of death due to unintentional injury in Kansas children ages 0-14 were (1) motor vehicle occupant in traffic, (2) airway obstruction, (3) fire and burn, (4) drowning, and (5) pedestrian. The death rate per 100,000 population was 15.4 for males and 9.8 for females. The unintentional injury death rate among black Kansans was 18.2/100,000 compared to 13.5/100,000 for the white race (1999-2001).²

The five leading causes of unintentional injury from hospital discharge data for children ages 0-14 (1999-2000) were (1) falls, (2) motor vehicle occupant in traffic, (3) poisoning, (4) struck by object or person, and (5) bicycle injuries.⁴

A traumatic brain injury was present in 26% of unintentional injury hospitalizations among children ages 0-14.⁴



We must continue our prevention efforts by:

- ☆Relying on sound research and data to develop and implement programs and effective interventions.
- ☆Increasing our public awareness efforts.
- ☆Finding additional resources for distribution of safety devices to at-risk families.
- ☆Advocating for stronger public policies such as closing the gaps in child occupant protection laws to protect children of all ages and encourage enforcement of existing laws.

Prevention is our most promising vaccine.

MOTOR VEHICLE OCCUPANT INJURY

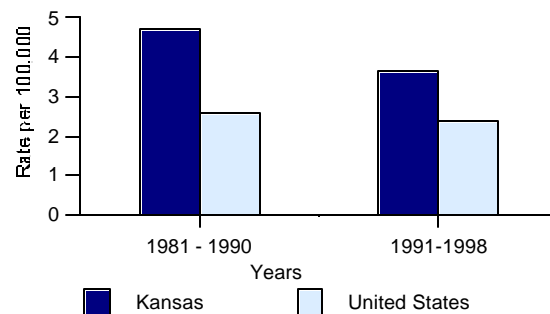


The Problem

Motor Vehicle Crashes are the number one cause of unintentional injury-related death for children ages 0-14 in Kansas.² Proper use of restraints greatly increases the chance of survival while decreasing the potential for injury. Research on the effectiveness of child safety seats in passenger cars has found them to reduce fatal injury by 71% for infants (less than 1 year old) and by 54% for toddlers (1-4 years old).¹²

There was a 23% decrease in motor vehicle crash death rates per 100,000 population for Kansas children ages 0-14 when comparing 1981-1990 and 1991-1998. Nationally there was a 7% decrease in the same time period.¹

**Mortality due to Motor Vehicle Crashes
Ages 0-14, 1981-1998**



Source: National Center for Health Statistics, CDC¹

The Kansas SAFE KIDS BUCKLEUP Program has been credited with 11 documented lives saved in the past two years.

Key Findings in Kansas Children Ages 0-14

☆ Traumatic brain injuries occurred in 56% of hospitalizations caused by crashes involving occupants of motor vehicles in traffic .⁴

☆ Comparing 1981-1985 and 1996-1998, mortality rates for motor vehicle traffic crashes have decreased the most in the 0-4 age group (53%), while only slightly decreasing in the 5-9 age group (4%), and actually have **increased** in the 10-14 age group by 14%.¹

☆ 29% of Kansas children ages 4-8 who were a passenger in a motor vehicle crash were seated in the front seat, compared to 23% nationally.⁵

☆ Of the 26 Kansas children ages 0-14 killed in motor vehicle crashes in 2001, 85% were not using safety belts or child safety seats. By calculating relative risk, this data estimates that children in a motor vehicle crash without a safety restraint are 39.0 times as likely to be killed as those with a safety restraint.¹³



Strategies for Prevention

☆ Support legislation designed to close the gaps in the existing state child passenger restraint law and improve its enforcement.

☆ Create public education campaigns regarding the appropriate use of belt positioning booster seats and the dangers that airbags pose to children age 12 and younger riding in the front seat of a vehicle.

☆ Provide child safety seats or incentives for purchasing child safety seats (including special needs seats) to low-income and disadvantaged families.

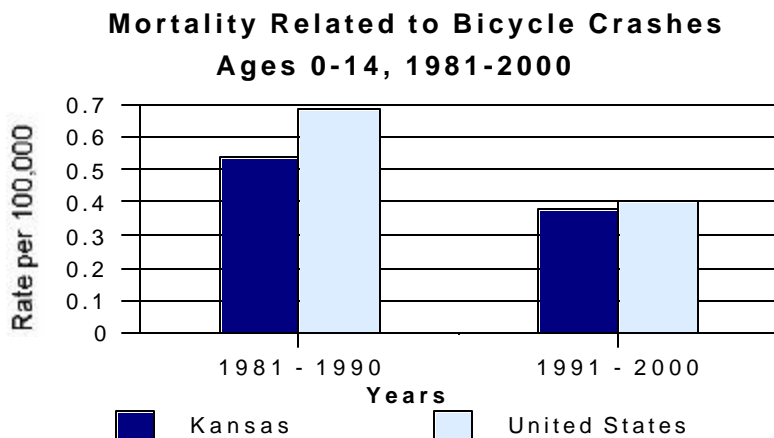
☆ Increase the availability of belt-positioning booster seats for children age 4-8.

Four out of five children are riding at risk because they are using the wrong type of restraint or their child safety seat is improperly installed.⁶

BICYCLE INJURY

The Problem

Bicycles are associated with more childhood injuries than any other consumer product except the automobile.⁶ On average (1999-2000), 168 Kansas children ages 0-14 die or are injured as a result of a pedal cyclist crash in traffic each year.³ Head injury is the leading cause of death in bicycle crashes and is the most important determinant of death and permanent disability.⁶



There was a 30% decrease in bicycle crash death rates per 100,000 population for Kansas children ages 0-14 when comparing 1981-1990 and 1991-2000. Nationally there was a 42% decrease in the same period.¹

Source: National Center for Health Statistics, CDC ¹

The Cycle Smart program in Kansas has been credited with 9 documented lives saved.

Key Findings in Kansas Children Ages 0-14

☆Traumatic brain injuries occurred in 45% of hospitalizations for injuries sustained during a bicycle crash. (1999-2000)⁴

☆On average, there were 49 hospital discharges each year from a bicycle crash-related injury for 1999-2000. Of those, 48% were in the 5-9 age group, and 78% were male.⁴

☆According to the Behavioral Risk Factor Surveillance System from 1999, 33% of Kansas children ages 5-14 as reported by an adult surrogate always wore a bicycle helmet which has **increased from 20% in 1995¹**.



Strategies for Prevention

☆Increase helmet usage rates for all children ages 14 and under who participate in wheel-related sports. The single most effective safety device available to reduce head injury and death from bicycle crashes is a bicycle helmet. The SAFE KIDS CYCLE SMART program distributes helmets at a discount cost to Kansas children through local organizations. The program also provides education about the importance and proper use of bike helmets.

☆Support efforts to enact comprehensive and enforceable local bicycle helmet use ordinances for children.

☆Promote the use of clothing and accessories that have incorporated retro reflective materials to aid in bicyclist visibility.

PEDESTRIAN INJURY

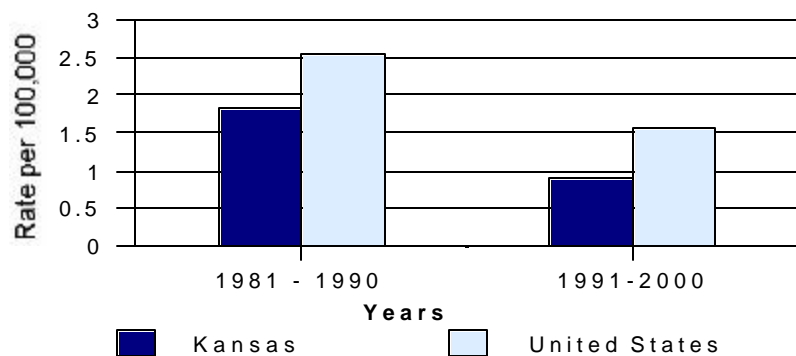
The Problem

Parents often overestimate their child's pedestrian skills. Children are impulsive and have difficulty judging speed, spatial relations, distance and velocity. They often dart into traffic without recognizing the danger.



There was a 50% decrease in pedestrian injury death rates per 100,000 population for Kansas children ages 0-14 when comparing 1981-1990 and 1991-2000. Nationally there was a 39% decrease in the same period.¹

Mortality due to Unintentional Pedestrian Injuries, Ages 0-14, 1981-2000



Source: National Center for Health Statistics, CDC¹

Key Findings in Kansas Children Ages 0-14

- ☆ The 5-9 age group had the highest percentage of hospitalizations in Kansas (43% according to hospital discharge data from 1999 and 2000).⁴
- ☆ The number of deaths is similar for the different age groups, 0-4, 5-9, and 10-14 (1999-2001).²
- ☆ Traumatic brain injury occurred in 30% of hospitalizations due to pedestrian injuries in a crash (1999-2000).⁴
- ☆ 86% of pedestrian unintentional injury hospitalizations (1999-2000) were the result of a pedestrian/motor vehicle collision in traffic.⁴

Strategies for Prevention

- ☆ Build public awareness through information and education about the dangers young pedestrians face on the streets, in driveways, parking lots, sidewalks, and off-road locations.
- ☆ Conduct specific education outreach to children ages 5 to 9 illustrating safe pedestrian behaviors. SAFE KIDS sponsors Walk Your Child to School Day each year for children grades K-3. The program addresses choosing a safe route to school, including basic safety rules that pedestrians should follow and identifying hazards to avoid.

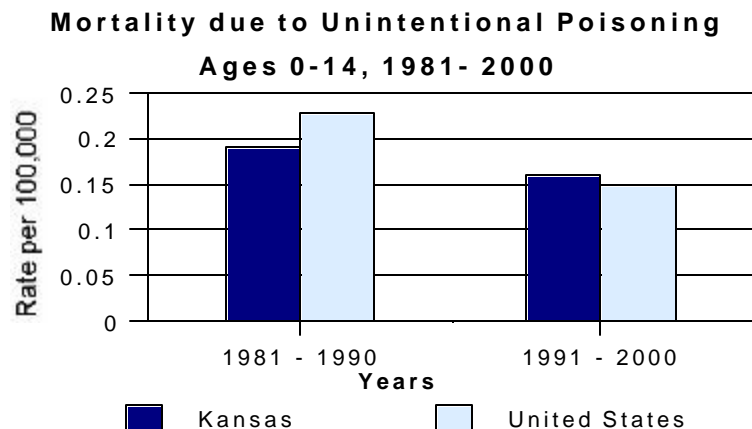
POISONING INJURY



The Problem

Young children constantly explore the world around them, touching and tasting everything they see. Their natural curiosity and tendency to put things in their mouths increases their risk of death from exposure to medicines and household products. Also, children are smaller, have faster metabolic rates and are less able to tolerate toxic chemicals, placing them at a significantly greater risk of poisoning than adults. Children are also poisoned by lead and carbon monoxide.

There was a 19% decrease in unintentional poisoning death rates per 100,000 population for Kansas children ages 0-14 when comparing 1981-1990 and 1991-2000. Nationally there was a 34% decrease in the same period.¹



Source: National Center for Health Statistics, CDC¹

Key Findings in Kansas Children Ages 0-14

☆ In 2001, the most frequent causes of toxic exposures reported to the Mid-America Poison Control Center in children ages 5 and under were cosmetic/personal care products (13%), household cleaning substances (10%), and analgesics (8%).⁷

☆ The 0-4 age group had the highest percentage of hospitalizations for unintentional poisoning (76%) (1999-2000). The highest number of hospitalizations involved 2-year-olds, followed closely by the 1-year-old age group.⁴

☆ In 2001, there were 17,586 reports of toxic exposures to the Mid-America Poison Control Center in Kansas. Of these, 64% involved children ages 5 and under.⁷

Strategies for Prevention

☆ Increase the use of and affordability of safety devices such as cabinet-latches and carbon monoxide detectors.

☆ Publicize the National Poison Control hotline number, 1-800-222-1222, and support the Mid-America Poison Control Center.

☆ Develop public information campaigns encouraging the use of child resistant packaging and increasing parental awareness of poisoning prevention strategies.

☆ Support efforts to enact local ordinances requiring carbon monoxide detectors in all residential dwellings that rely on the combustion of fossil fuel for heat, ventilation, or hot water.

☆ Support efforts to reduce the use of inhalants and alcohol ingestion by children.

Fire and Burns

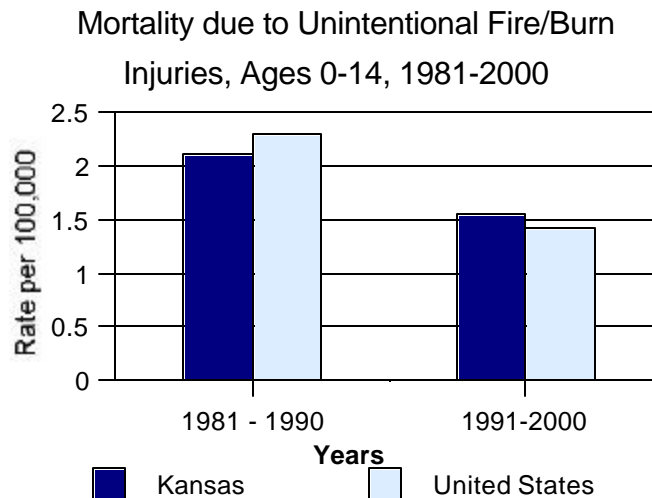


The Problem

Young children are at the greatest risk of fire death. They do not have a strong perception of danger, have less control of their environment, and have a limited ability to react promptly and properly to a fire. Child-play fires are the leading cause of residential fire-related death and injury among children ages 9 and under.⁹

An estimated three-fourths of fire-related deaths are from smoke inhalation. Children are more susceptible to asphyxiation because their small bodies are less able to tolerate toxic combustion products. And because children have thinner skin than adults, their burns can be deeper at lower temperatures. In addition to fire burns, children are also at risk of scald, electrical, thermal, chemical and radiation burns.

There was a 27% decrease in unintentional fire/flame injury death rates per 100,000 population for Kansas children ages 0-14 when comparing 1981-1990 and 1991-2000. Nationally there was a 38% decrease in the same period.¹



Source: National Center for Health Statistics, CDC¹

Key Findings in Kansas Children Ages 0-14

☆The 0-4 age group had the highest percentage of deaths (56%) due to unintentional fire/flame injuries (1999-2001).²

☆In contrast, the age group with the highest percentage of hospital discharges from a fire/flame injury were ages 10-14 (45%). Discharge data also showed that 19% of hospitalizations due to fire/flame injury were ages 0-4 and 35% were ages 5-9 (1999-2000).⁴

☆While there was no significant gender difference in deaths², for every female hospitalization, there were almost 7 male hospitalizations⁴.

☆Home was specified as the place of death in 89% of fire/flame related deaths in 1999-2000; 11% occurred at either an unknown or an unspecified place.²

☆According to the Behavioral Risk Factor Surveillance System from 2002, 87% of households have an installed and working smoke alarm. 76% of households have a functioning smoke detector on every level of the home and outside each sleeping area.

☆Eighty-seven percent of hospital discharges due to hot object/scald burn were ages 0-4 (1999-2000).⁴

Strategies for Prevention

☆Continue the distribution and installation of smoke detectors and carbon monoxide detectors through the SAFE KIDS Get Alarmed program to families most in need.

☆Continue efforts to educate Kansans about the Kansas Smoke Detector Law and encourage the public to develop and practice residential fire escape plans.

☆Provide a bilingual, interactive 9-1-1 Simulator for use by community groups that teaches children how to properly use the 9-1-1 emergency number in their area.

☆Endorse policies that limit children's access to lighters and endorse enhancements to standards for child resistant lighters.

☆Provide public education about the need to reset hot water heaters to prevent water temperatures above 120 degrees Fahrenheit.

☆Increase efforts to prevent juvenile fire setting through the Y-Fire Program.

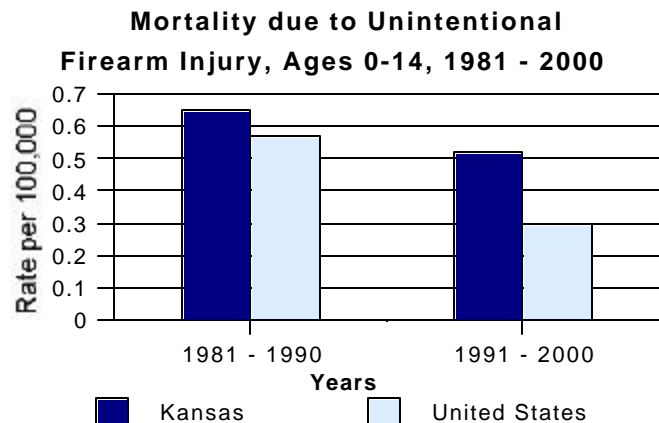


Unintentional Firearm Injury

The Problem

Some parents think their children are not at risk because they do not own guns. Other parents think their kids are safe because they do own guns and the kids know “the rules”. Many parents misjudge a child’s ability to gain access to a gun and fire it. They fail to realize that children have difficulty distinguishing between real and toy guns, can’t make good judgements about handling a gun and do not consistently follow rules about gun safety.

There was a 20% decrease in unintentional firearm injury death rates per 100,000 population for Kansas children ages 0-14 when comparing 1981-1990 and 1991-2000. Nationally there was a 46% decrease in the same period.



Source: National Center for Health Statistics, CDC¹

Key Findings in Kansas Children Ages 0-14

☆Children ages 10-14 have the highest rate of unintentional firearm injury-related death among all children ages 0-14 in Kansas and nationally.¹

☆The air gun was the type of firearm that caused the highest percent of hospitalizations (1999-2000).⁴

☆Almost all unintentional firearm injury hospitalizations among children ages 0-14 in 1999-2000 were males.⁴

☆According to the Behavioral Risk Factor Surveillance System from 2001, 38% of households in Kansas reported having firearms in or around their home.

Strategies for Prevention

☆Continue the distribution of safe storage devices to families with young children. Distribution programs should be coupled with effective education materials.

☆Create public information campaigns designed to increase gun owners’ awareness of the importance of safe storage.

☆ Encourage proper age-appropriate use of air guns by children.

☆Support enactment of Child Access Prevention (CAP) laws, also referred to as “Safe Storage” laws, which require adults to either store loaded firearms in a place that is not accessible to children, or use a device to lock the gun.

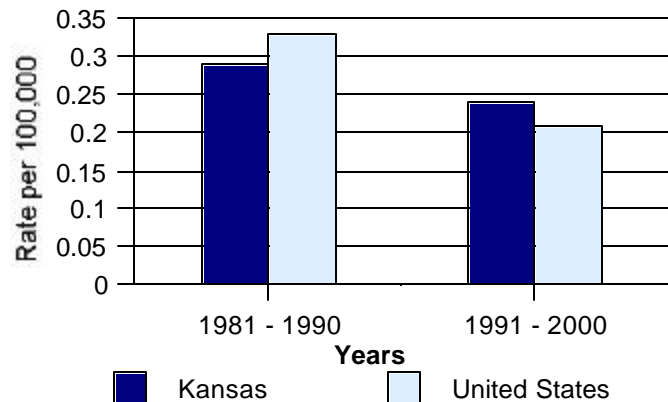
FALLS INJURY

The Problem

While falls are the sixth leading cause of unintentional injury death for Kansas children ages 0-14 (1999-2001)², fall injuries accounted for the highest frequency of hospitalizations due to injuries in children ages 0-14 (1999-2000)⁴. The majority of falls occur from furniture, stairs, windows, baby walkers and playground equipment.⁶

There was a 16% decrease in unintentional fall injury death rates per 100,000 population for Kansas children ages 0-14 when comparing 1981-1990 and 1991-2000. Nationally there was a 37% decrease in the same period.¹

**Mortality due to Unintentional Falls
Ages 0-14, 1981-2000**



National Center for Health Statistics, CDC¹

Key Findings in Kansas Children Ages 0-14



☆Children ages 0-4 have the highest rate of deaths caused by unintentional falls (1981-2000).¹

☆From 1999-2000, 44% of children hospitalized with unintentional fall injuries were ages 0-4.⁴

☆Traumatic brain injuries occurred in 33% of hospitalizations due to an unintentional fall injury (1999-2000).⁴

Strategies for Prevention

☆Increase public awareness of the Consumer Product Safety Commission playground safety guidelines and increase the number of Kansas playgrounds that meet those standards.

☆Discourage the use of mobile baby walkers and encourage replacement with stationary alternatives.

☆Distribute public education/information on the most common causes of fall-related injuries and effective safety precautions.

AIRWAY OBSTRUCTION INJURY

The Problem

Airway obstruction injury is the leading cause of unintentional injury-related death among infants under age 1.⁶ These injuries occur when children are unable to breathe normally because food or objects block their internal airways (choking), materials block or cover their external airways (suffocation), or items become wrapped around their necks and interfere with breathing (strangulation). Children, especially those under age 3, are particularly vulnerable to airway obstruction death and injury due to their small upper airways, their relative inexperience with chewing and their natural tendency to put objects in their mouths. Additionally, infants' inability to lift their heads or extricate themselves from tight places puts them at greater risk.

There was a 30% decrease in airway obstruction injury death rates per 100,000 population for Kansas children ages 0-14 when comparing 1981-1990 and 1991-2000. Nationally there was a 16% decrease in the same period.

Key Findings in Kansas Children Ages 0-14

☆ In 1999 and 2000, 46% of unintentional injury hospitalizations due to airway obstruction were the result of inhalation and ingestion of food causing obstruction of the airway; 42% were the result of inhalation and ingestion of a foreign body.⁴

☆ 39% of unintentional airway obstruction deaths in the under 1-year-old population were due to suffocation and strangulation in bed.²

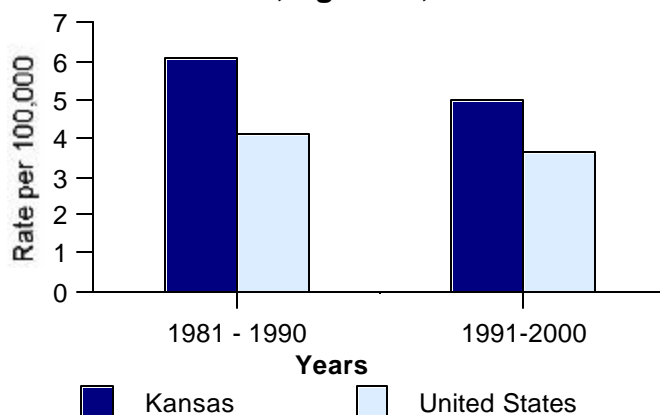
Strategies for Prevention

☆ Increase public awareness about choking, suffocation and strangulation hazards. Provide education about correct sleeping positions and environments for infants.

☆ Publicize emergency contacts and community resources for training the public in infant and child CPR and choking first aid.

☆ Work with the Consumer Product Safety Commission and manufacturers to improve the design of baby furniture and other juvenile products as well as enforcing warning label requirements on toys.

Mortality due to Unintentional Airway Obstruction, Ages 0-4, 1981-2000



National Center for Health Statistics, CDC¹

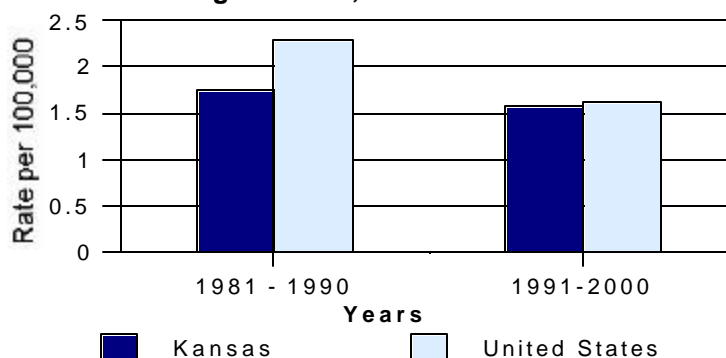
DROWNING INJURY

The Problem

Drowning deaths are the fourth leading cause of unintentional injury death for Kansas children ages 0-14.² While the majority of drownings and near-drownings take place in residential swimming pools, children can drown in as little as one inch of water. Wading pools, bathtubs, buckets, diaper pails and toilets can be extremely unsafe for an unsupervised child. Open water sites such as lakes, rivers, canals, oceans and drainage ditches are also high-risk drowning sites.

There was a 9% decrease in drowning death rates per 100,000 population for Kansas children ages 0-14 when comparing 1981-1990 and 1991-2000. Nationally there was a 29% decrease in the same period.¹

**Mortality due to Unintentional Drowning
Ages 0-14, 1981-2000**



Source: National Center for Health Statistics, CDC¹

Key Findings in Kansas Children Ages 0-14

☆65% of unintentional drowning deaths are in the 0-4 age group. This age group also had the highest percentage of hospitalizations for near drowning.⁴

☆60% of hospitalizations in children ages 0-14 for near drowning were male.⁴

☆40% of deaths occurred in a swimming pool, while 30% occurred in a bath tub, 15% occurred in a natural body of water, and in 15% of deaths, place was unspecified.²

Strategies for Prevention

☆Increase public awareness about how quickly and unexpectedly drowning can occur, and the importance of adult supervision.

☆Increase the number of residential pools with four-sided fencing.

☆Endorse efforts to reduce drowning injuries due to infant bath seats and five-gallon buckets.

☆Endorse and encourage enforcement of boating safety laws requiring children to wear personal flotation devices when on boats or in open bodies of water.



Traumatic Brain Injury

The Problem

While unintentional injury is the leading cause of death among children ages 1-14, traumatic brain injury (TBI) is the most deadly type of injury. The results of a TBI can range from temporary hospitalization to rehabilitation, permanent disability or even death. Injuries associated with participation in sports and recreational activities account for 21 percent of all traumatic brain injuries among children in the United States. Nearly half of all sports-and recreation-related head injuries to children are caused by bicycle, skating and skateboard incidents. A recent national study found that 63% of “tweens” (ages 8 to 12) do not think they could suffer a brain injury while riding on wheels, yet the reality is nearly half (47%) of children hospitalized nationally for bike-related injuries suffer from a traumatic brain injury.¹⁰

Key Findings in Kansas Children Ages 0-14

☆ There were 75 unintentional injury deaths with a traumatic brain injury (TBI) in Kansas ages 0-14 from 1999 through 2001 (4.3 deaths/100,000 population).²

☆ The highest percentage of these TBI deaths were the result of occupant injuries in motor vehicle crashes (61%) followed by pedestrian injuries (12%).²

☆ The highest percentage of unintentional injury deaths with a TBI was in the 10-14 age group (44%) followed by the 0-4 age group (33%) and the 5-9 age group (23%).²

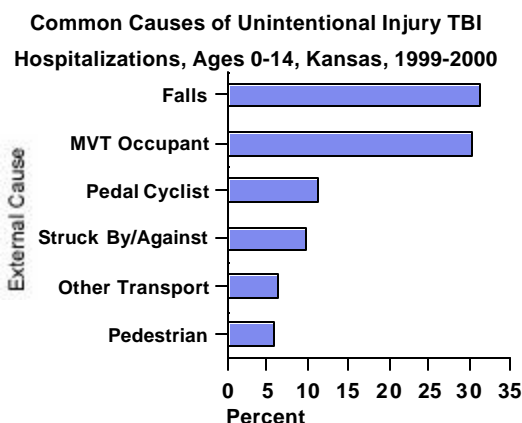
☆ 61% of unintentional injury deaths with a TBI were male.²

☆ The highest percentage of unintentional injury hospitalizations with a TBI was in the 0-4 age-group (36%), followed by the 10-14 age group (34%) and the 5-9 age-group (30%).⁴

☆ 64% of unintentional injury hospitalizations with a TBI were male.⁴

☆ Falls accounted for the highest percentage of unintentional injury TBI hospitalizations followed closely by motor vehicle occupant in a crash.⁴

☆ A traumatic brain injury occurred in 45% of hospitalizations for injuries sustained during a bicycle crash among children ages 0-14 (1999-2000).⁴



Source: Kansas Hospital Association

Pedal cyclist includes both in traffic and non-traffic bicycle crashes.

Struck by/ against includes:
Hit, struck by an object such as rock, ball, or hockey stick, or struck by another person such as in a football game or human stampede.

Other transport includes:
Crashes involving railway cars, non-traffic motor vehicles such as snowmobiles and ATV's.

Pedestrian includes both in traffic and non-traffic crashes.

Technical Notes

This report used data available through WISQARSTM (Web based Injury Statistics Query and Reporting System) to compare Kansas and national death rates in 2 time periods, 1981-1990 and 1991-2000. These 2 time periods were selected to allow stability due to small numbers in some risk areas and to compare crude unintentional death rates before SAFE KIDS began developing coalitions in Kansas to a second time period when SAFE KIDS along with its partners were developing child safety programs.

Unintentional injury death rates are defined as the number of deaths per 100,000 population. Death trends were presented for the principal causes of childhood unintentional injury-related death: motor vehicle occupant injury, pedestrian injury (including both traffic and non traffic), bicycle-related injury (including both traffic and non traffic), drowning, fire and burn injury, airway obstruction injury (including suffocation and choking), firearm injury, falls and poisoning. In addition, death rates were analyzed by age group (ages 0 to 4, ages 5 to 9 and ages 10 to 14), and sex. The under 1 population was presented in 2 areas of injury, motor vehicle occupant and airway obstruction. Race was only included in unintentional injury overall due to potential instability related to small numbers in other races except white when specific unintentional injury causes were analyzed.

Injury and poisoning deaths as well as hospital discharges are classified according to the injury codes of the World Health Organization's International Classification of Diseases (ICD). The tenth revision of the ICD (ICD-10), adopted in the U.S. in 1999, replaced the external cause codes of the ninth ICD revision (ICD-9) with an alphanumeric coding system, which may affect the ability to compare years before and after 1999. Preliminary comparability ratios, which measure discontinuity between ICD revisions, were provided by NCHS and are provided in Table 1, along with the ICD-9 and ICD-10 codes used for the mortality comparison between national and state data. In order to account for injury coding changes that occurred between 1998 and 1999, trends were adjusted by applying comparability ratios to death numbers for years prior to 1999.

Caution should be taken when comparing mortality and morbidity data. Hospital discharge data uses ICD-9-CM coding and mortality data, starting with 1999, uses ICD-10 coding. ICD-9 classification includes an external cause code (e-code) to identify the cause and intent of the injury or poisoning (n-code). The ICD-10 classification system uses an alphanumeric coding system denoting both the nature of injury and external causes. In this report hospital discharge data may be referred to as either hospital discharges or hospitalizations. Approximately 60% (1999-2000) of injury related hospital discharges included an external cause of injury code (e-code). Therefore, the findings in this report likely under estimate the overall burden of injury in the state of Kansas.

The Behavioral Risk Factor Surveillance System is a population based telephone survey system. For children 0-14, data is reported by a surrogate. Thus, there may be biases in reporting behaviors of children in the household.

TABLE 1. ICD Coding for mortality comparisons and corresponding comparability ratios.

Cause of Unintentional Injury	ICD-9 Coding	ICD-10 Coding	Comparability Ratio
Unintentional Injury Overall	E800-E869, E880-E929	V01-X59, Y85-Y86	1.0305
Airway Obstruction	E911-E913	W75-W84	1.330682
Drowning/Submersion	E830, E832, E910	W65-W74	0.901274
Fall	E880-E886, and E888	W00-W19	0.978068
Firearm	E922	W32-W34	1.11036
Fire/Burn	E890-E899, E888	X00-X19	0.97963
Motor Vehicle Traffic Occupant	E810-E819 (.0,.1)	V30-V79 (.4-.9), V81-V82 (.1), V83-V86 (.3).	----*
Pedal Cycle (traffic and nontraffic)	E800-E807 (.3), E810-E825 (.6), E826.1,.9, E827-829 (.1)	V10-V18, V19(.0-.6,.8-.9)	0.977778
Pedestrian (traffic and non-traffic)	E800-E807 (.2), E810-E825 (.7), E826-E829 (.0)	V02-V04 (.0,.1,.9), V01,V05,V06,V09 (.0,.1,.2,.3,.9)	0.996185
Poisoning	E850-E869	X40-X49	0.886161

*no comparability ratio available at this time

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